Comments on the MIFamily Proposal Received by the Department of Community Health

Below are the comments on the MIFamily proposal received by the Department of Community Health through February 19, 2002. A line separates each individual or organization's comments. In most instances, the name of the person commenting has been omitted; in some instances an organization's comments include the name of the organization in the body of the comments.

The Department answers questions raised in the comments and the answers are highlighted in yellow. The Department does not respond to general comments and suggestions in this document, but all of the comments and suggestions will be considered in the development of the draft waiver document. The draft of the waiver is posted on the Department's web site (www.mdch.state.mi.us) and it will be available for additional comments and suggestions. DCH will accept comments through February 28, 2002.

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1) Number of current SMP recipients? Currently there are approximately 50,000 individuals enrolled in the SMP program.
2) For each of the 7 counties, number of persons eligible in county programs in their first year of operation and number of SMP recipients in those counties the year before the county program began. This data is not available since 4 of the counties only began operation in November 2001. SMP eligibility continues to be determined by the local FIA offices in each of the counties. In addition, eligibility for the county program may be determined in additional sites.
3) Will counties be mandated to provide at least the Plan D coverage to at least those who qualify for Plan D if they choose to operate a county program? Yes, the state will establish minimum coverage requirements that must be met for a county to participate in the program. The county may supplement the basic package by adding additional services if local resources are available.
4) For the most recent available period, number of persons who qualified for SMP by meeting a spenddown. SMP clients are not on the system until they meet their spenddown so it is not possible to determine the number of spenddowns from the data available. We believe the number of SMP clients meeting a spenddown is very small statewide based on FIA experience.

Thank you for having a public hearing on HIFA and the MIFamily program. I am still confused, however, as to how this expansion of services is to be funded. Currently every CMHSP gets a certain amount of funding ("Per Member Per Month") for all people who are eligible for Medicaid services, in the county (ies) they cover. If more Medicaid eligible persons are found (or, in a sense, created) by this waiver, will there be a corresponding increase in the number of Per Member Per Month allottments? In other words, will there be a corresponding increase in funding to CMHSPs? Yes, CMHSP funding under the waiver will be on a per member per month (PMPM) basis. The Department is currently analyzing data from the CMHSPs to ensure that funding under

the waiver is adequate to meet the expected costs of providing services to the waiver population. In addition to the PMPM payment to the CMHSPs, funding provided through the waiver will result in an across-the-board fee increase for the CMHSPs.

1) The number of people who stand to benefit from the higher 1619(b) ceiling proposed is disappointingly small. It is our understanding from the Social Security Administration (SSA) that there are about 4,000 people in Michigan who have qualified for Section 1619(b). Many more people with disabilities fear losing their health coverage, including people on SSDI who are on spend down, people who have not been able to access Section 1619(b), and people with disabilities who, for whatever reason, are not on SSI or SSDI. For people with disabilities, maintaining their health is critical to seeking or maintaining employment.

The vast majority of SSI recipients want to work–-our own survey found that 78.5% of persons with disabilities who are not working would choose to work if they could retain their health care coverage. The reason that the Section 1619(b) group is so small is the great difficulty people have in accessing the program, and the great risks they incur should SSA suddenly make an adverse decision about their continued eligibility--a problem acknowledged by national and regional managers of SSA. We hear countless complaints from SSI recipients about SSA field staff who either know little or nothing about Section 1619(b), or who discourage potential applicants with confusing or negative information.

It was often repeated by the Department of Community Health (DCH) staff that the proposed new waiver would be in addition to existing programs and waivers. Thus, a person with a disability who is an SSI recipient, whether not working or working on 1619(a), could not accept a job offer of, say, $25,000 a year without losing Medicaid. Although that amount is under the proposed higher 1619(b) ceiling of $31,118, he or she would first have to qualify for 1619(b) under the existing program where the ceiling is $21,886. A person on SSI would be able to accept the $25,000 per year job under the proposal and not lose her Medicaid coverage. The proposal is to increase the upper limit for coverage to 350% of the federal poverty level for persons who are either on SSI or 1619(b).

The Mi Family proposal as presented does not address any of these issues, and consequently it will have limited effect on employment barriers facing people with disabilities.

2) DCH staff stated that the MiFamily Section 1115 waiver would allow participants in this expanded coverage plan to save for retirement beyond the current $2,000 asset limit. Denise Holmes indicated that DCH welcomes suggestions on this issue. Recommendations were made at the forum but we have not yet received confirmation as to whether the Department contemplates easing the asset limit in any other way. People with disabilities face many challenges in maintaining employment. Accessible vehicles are expensive and can break down. Savings may be needed for down payments or modifications of homes. Purchases may be needed for equipment not covered by

Medicaid. Without the ability to accumulate savings and create a financial cushion, a person with a disability is more at risk of losing a job due to circumstances beyond his or her control.

The MiJob Coalition gave careful consideration to this issue and has adopted the position that there should be no asset or income limitations for working people with disabilities retaining Medicaid coverage. This would permit these individuals to build a financial cushion and would also certainly simplify program administration.

We continue to support establishment of a Medicaid Buy-In program that permits people with disabilities to pay premiums for Medicaid as their incomes rise and their assets accumulate. In addition, since one of the parameters of HIFA waivers is budget neutrality, elimination of asset restrictions would have no effect on Medicaid expenditures--particularly in light of the extremely small size of the group to be affected.

3) A hidden issue with the Mi Family proposal is the potential consequence for people on SSI who retain their Medicaid coverage as they pursue their employment objectives on 1619(a) or 1619(b), and eventually develop ten years of work experience. If they should be forced to stop working for reasons related to disability, they would become eligible for SSDI and Medicare instead of SSI and Medicaid because of the length of their work record. This is potentially disastrous if they depend upon prescription drugs, personal assistance services or durable medical equipment – benefits not covered by Medicare. Risking the loss of Medicaid would be a great disincentive to beginning or returning to work with 1619(a) or 1619(b) benefits for any participant who takes the trouble to research the pitfalls.

We would have welcomed the opportunity to discuss the Mi Family proposal as it was being developed. As you know, we have been asking for such a dialogue for the last two years. We believe that the early participation of intended beneficiaries, advocates and other concerned citizens strongly influences the degree to which program design and implementation can achieve the intended laudable outcomes. At this late stage, we were disappointed that we were not afforded the opportunity to see a complete written proposal on which to comment. Will we have the opportunity to see the full written proposal and make further comments before it is submitted to CMS? The draft waiver is posted on the Department's web site (www.mdch.state.mi.us) and the Department will accept comments on the draft through February 28.

I commend the Department for seeking to: capture increased federal support for health care; expand health coverage to certain low-income uninsured; make positive use of all CHIP funds to which the state has access; establish 12-month eligibility for children under Healthy Kids Medicaid; and create more seamless care access for the current SMP population.

I do not commend the Department for: denying since last summer that an 1115 waiver was being considered; failing to involve any outside groups in related discussions prior to the Feb. 4 public forum; giving the public only one week from Feb. 4 to make written

comment; and refusing to meet on or before Feb. 11 with a coalition of health care groups requesting such a session.

I respectfully offer several specific comments and questions, as follow:

*What is the rationale for offering full Medicaid benefits to pregnant women at 186-200% FPL but not other expansion populations? Coverage for pregnant women has been expanded over a number of years to 185% of the federal poverty level (FPL). The MIFamily waiver would expand this coverage further to 200% of the FPL. Expansion to 200% allows the Department to price the other coverages without including pregnancy related services and that results in overall savings. In addition, the expansion allows county programs to expand coverage without having to include pregnancy related services. Covering pregnant women to 200% is also a federal priority for unexpended SCHIP funds.

*Why is expanded income earning limited to the 1619(b) population? It is not limited to the 1619(b) population; the expansion would also apply to the 188,000 beneficiaries who are currently on SSI. Expansion of 1619(b) coverage to 350% of the federal poverty level (FPL) will allow currently disabled people on either SSI or 1619(b) to earn additional money without losing their existing Medicaid coverage. The expansion will also allow the Department to study the effects of expanded income and asset eligibility for a disabled population. The expansion will be available to all 188,000 people who currently receive SSI or 1619(b) coverage. It is my understanding that this presently encompasses only 4,000 state residents, and that 1619(b) is difficult to access and poses other barriers to working (e.g., assets) aside from annual income.

*Person who would fall under DCH's Plan B currently have full Medicaid access with little cost-sharing. Under the Department's "initial thinking," this population would face loss of or reductions in numerous benefits, as well as onerous cost-sharing. Parents at or below 50% FPL should retain all current benefits without increased cost-sharing.

*Plans B & C would eliminate those age 19 and 20 from EPSDT coverage. This should not be allowed to happen.

*Proposed cost-sharing throughout Plans B, C and D would represent a major barrier to service access, and would prevent realization of the new service population numbers DCH hopes to achieve. The proposed co-pays should be eliminated. If they are not, will they be consumer out-of-pocket payments or service reimbursement deductions? Based on comments received at the public forum and through the comment period, the Department is reviewing all copayments included in the initial draft of the MIFamily proposal. An unpaid copayment would result in lower fees received by the provider. Additionally, does not Michigan have "prudent layperson" standards regarding ER use, and (if so) how does that mesh with the ER co-pay language under B, C and D? The Department uses a prudent layperson standard for determining the appropriateness of ER use.

*What is the rationale for limiting inpatient service under Plan C to 5 days (at $500 per)? That is far too restrictive. The limitation on the inpatient benefit was established to make the benefit affordable. This will allow more people to be covered. Statistics indicate most people in the group will be young, healthy adults who primarily need preventive services, pharmacy and outpatient care. The Department is reviewing all benefits based on comments received.

*Parents above 100% FPL presently have the opportunity to spend-down to 50% FPL. What can and will be done so that low-income parents above 100% FPL aren't completely shut out of any opportunity for coverage? The MIFamily coverage does not include provisions for a spenddown. People who are over income for coverage will not be able to spenddown excess income as they can now under some Medicaid categories. The Department has reviewed the effect of eliminating spenddown and believes that it is a prudent trade-off to allow more individuals to receive basic coverage. In addition, most people (over 96% in a sample of 2,000) over 100% of the federal poverty level who are now on spenddown do not meet the spenddown in a 12-month period and receive no coverage. People will become eligible under the MIFamily coverage if their income drops below 100% of the FPL for the month.

*There is a somewhat similar spend-down opportunity at present for the SMP. What can and will be done so that childless adults who are indigent but above 35% FPL won't be completely shut out of any opportunity for coverage? Coverage for childless adults from 36% to 100% of the federal poverty level will be phased in statewide over the life of the waiver as counties choose to participate in the provision of health coverage for this population.

*The material and information presented Feb. 4 would not improve the spend-down situation for the DAB population. The waiver opportunity should be used to index the Protected Income Level for DAB spend-down at the federal Substantial Gainful Activity level (currently about twice the PIL in Michigan). I suggest this rather than a Plan C-like approach because the latter would provide too limited a benefit for individuals who are highly vulnerable, and would drive all those not meeting the established poverty level ceiling into uncompensated care.

*What is the rationale for not offering parents an equivalent package to what is available through CHIP? Providing the current MIChild benefit to the parent population would be extremely expensive and would greatly reduce the number of people who could be provided coverage under the expansion. Has an analysis of the additional cost been conducted? The waiver benefit package has been developed in consultation with the Department's actuary and is designed to provide appropriate coverage tailored to the needs of the covered group. Cost is an important consideration since it directly affects the number of people that can be covered. The MIFamily group will be, for the most part, a healthy adult population that is most in need of outpatient and pharmacy services. These services are covered in the proposed benefit package. If so, what were its results?

*What services presently available through SMP would be lost in switching that group to an "HMO-like benefit?" No currently covered service would be lost to the SMP group.

*Who will manage service delivery for all the new "HMO-like benefit" populations envisioned? A Variety of options may be developed. Existing HMOs and county health plans will manage benefits for many beneficiaries. Some beneficiaries may receive services through an employer sponsored health plan if one is available.

*What happens to existing county medical program benefits which exceed the uniform package developed for expansion to a greater number of counties? For example, there is no inpatient benefit under Plan D, but Wayne County's medical program currently offers that service. Will it have to go, or may it remain at the county's discretion? If the latter, under what conditions? Services above the basic package established by the waiver will be available at the county's discretion.

*The possibility of enrollment caps and annual adjustments to benefits and cost-sharing represents an area of great uncertainty for any analysis of an 1115 submission. Material distributed Feb. 4 stated that premiums for Plans C and D may be established in the future, and "Benefits and eligibility…will be reviewed annually through a public process." DCH should publish and widely disseminate a detailed operational definition of "a public process."

*Will an 1115 submission seek federal approval for any new pharmaceutical coverages, policies or processes? The HIFA waiver will not propose new pharmacy policies.

*Mental health is an area of great concern. Plans C and D would add an unknown number of new clients with a Medicaid entitlement to CMHSPs, and Plan D would further move an unknown number of SMP individuals into entitlement status vis-à-vis CMH service. What methodology did DCH use to project the amount of additional funding needed for CMHSPs to meet all new entitlement demands? What is the basis for concluding that a $56 million reduction in CMH non-Medicaid appropriations won't be harmful to those CMH clients who remain outside the scope of Medicaid? How has DCH determined that CMHSPs need $56 million in '03 for the SMP population when the statewide number of SMP individuals served by CMH isn't known? Since the $56 million assumption kicks off a chain reaction of important fiscal steps, what happens if that assumption proves inaccurate? Given Dave Viele's statement Feb. 4 that a separate (presumably lower) rate cell will be created for new CMH Medicaid clients, does this mean the service package which CMHSPS can offer them will be lesser than for other Medicaid enrollees? If so, how does that mesh with the Medicaid mental health services that are to be available under the existing 1915(b) waiver? Mr. Viele also said a consistent pharmacy strategy will be needed re CMH General Fund dollars. What are the Department's initial thoughts on what such a strategy might be? Mental health funding is an important part of the proposed waiver. The Department's initial draft has proposed an approximate $50 million dollar increase in funding for the CMHSPs. The Department is continuing to refine its funding proposal in this area to ensure that funding to each CMHSP is adequate

to meet the service needs of the newly enrolled population and that no CMHSP is harmed under the proposal.

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1. We feel that the asset limit of $2000 has been in effect for many years and needs to be increased. People with a disability need to save for such things as a down payment for a home of their own, the purchase of assistive technology and other commodities that will help the individual become independent. We believe that this asset limit should be substantially increased or completely go away. The cost of living for the individual has increased and minimum wages have gone up many times since the $2000 limitation was put into effect. We believe this would mean more to an individual than being able to pay into a retirement account. The Department is reviewing the proposed asset exclusions for the 1619(b) population based on comments received from the public.
2. Giving an individual with a disability the opportunity to earn more with out fearing the loss of health insurance coverage will go a long way to encourage these people to become more independent. We feel that this part of your proposal is the way to go.
3. We have some problems with the proposed co-pays for the people that are already at or below the FPL. This would shrink an already very low level of expendable income that they have. We are concerned that they will have to cut back on food and other necessary items.
4. We are concerned that this could be only the first step before the State goes after the super waiver. We would like to have assurances that this is not the ultimate goal of the state.

Dental Clinics North, Northwest Michigan Community Health Agency, had the opportunity to serve the low income uninsured in Year 2001 and currently with a limited grant from MDCH. The patients we served are in critical need of oral health care and have gone without for a very long time. There needs were frequently extractions and dentures. It is essential that both extractions and dentures are available to any new groups, especially the very low income adults.

This is essential to their health to be able to have teeth for basic nutritional purposes let alone possible employement opportunities.

PLEASE INCLUDE ADULT DENTAL SERVICES PER CURRENT MEDICAID POLICY IN YOUR PLANS! TO DO OTHERWISE WILL IGNORE A VERY IMPORTANT HEALTH ISSUE FOR THE LOW INCOME ADULTS THAT THE WAIVER WILL REACH!

I understand that you support the following, which I also SUPPORT:

- Full use of the state¹s SCHIP allotment

- Maximizing use of federal funds
- 12 month eligibility for children under Healthy Kids Medicaid
- Efforts to expand health care for uninsured, childless adults
- Efforts to expand health care for pregnant women and working persons with disabilities

I understand you might support the following, which I OPPOSE:

- Elimination of Medicaid eligibility for parents over 100% of poverty and 19-20 year olds over 35% of poverty (The Department's proposed HIFA waiver does not affect coverage for the Under 21 Medicaid group.)
- Elimination of eligibility for health coverage (currently State Medical Program) for childless adults over 35% of poverty (The Department's proposal phases in county health plan coverage for childless adults to 100% of the federal poverty level over the life of the waiver.)
- Co-payments, premiums, or other cost sharing for persons living below poverty level (The Department is reviewing all copayments based on comments received.)
- Limited Medicaid benefits for caretaker relatives

I have the following concerns, which I hope you address:

- Maintain current benefits for current recipients; do not fund benefits for new recipients on the backs of current recipients
- Provide meaningful opportunity for consumer and advocate input in developing health policy and programs under this waiver
- Assure adequate funding to pay for services or benefits that are part of coverage packages
- Assure a sufficient pool of providers in all geographic areas

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For the MIFamily waiver, it would be helpful to be able to use the MIChild and Healthy Kids Application to determine eligibility for both the children and their parents.

I am writing to let you know my feelings regarding the proposed health care expansion plan. I support the use of the state's SCHIP allotment and maximizing the use if federal funds.
I also support the efforts to expand health care for uninsured, childless adults, working people with disabilities and pregnant women. As well as the 12 month eligibility for children under Healthy Kids Medicaid.
I oppose the elimination of Medicaid eligibility for parents over 100% of poverty and 19-20 years old over 35% of poverty. I also oppose the elimination of eligibility for health coverage for childless adults over 35% of poverty, as well as the co-payments, premiums

or other cost for persons living below poverty level. I also oppose the limited Medicaid benefits for caretaker relatives.

I have concerns about the lack of meaningful opportunity for input by consumers and advocates in the development of the policy and programs under this waiver. It is not clear that there will be adequate funding to pay for services or benefits that are part of the coverage packages and to ensure an adequate pool of providers in all geographic areas. It is also not clear that there will be adequate funding to sustain current benefits to current recipients

I would like to lodge my concerns about the Medicaid Health Insurance Flexibility Waiver that I understand is being developed by the Department of Community Health for submission to the federal government. Although certain aspects of the plan seem laudible, other aspects concern me. Specifically:

** Elimination of Medicaid eligibility for parents over 100% of poverty and 19-20 year olds over 35% of poverty

** Elimination of eligibility for health coverage (currently State Medical Program) for childless adults over 35% of poverty

** Co-payments, premiums, or other cost sharing for persons living below poverty level

** Limited Medicaid benefits for caretaker relatives

** Lack of meaningful opportunity for input by consumers and advocates in the development of health policy and programs under this waiver

** It is not clear that there will be adequate funding to pay for services or benefits that are part of coverage packages, and to ensure an adequate pool of providers in all geographic areas

** It is not clear that there will be adequate funding to sustain current benefits to current recipients

As a former Health Care Financing Administration reviewer of state 1915(b) and 1115 waiver proposals, I am familiar with states' desires to expand access to health insurance for the working poor, while restraining expenditure growth for health insurance to their existing categories of Medicaid eligible populations.

Nevertheless, I fear that this waiver proposal may seriously undercut the interests of many poor people who currently benefit from some health care coverage through the State Medical Program. From the eyes of the public (and the press), I fear that the state's waiver proposal will look like an

attempt to help cover the state budget shortfall on the backs of poor people. I am sure you don't want that to be the public's perception.

Plusses in the Proposal

We are pleased that the state is seeking approval to use its unused SCHIP funds as well as other funds available through the DSH funding mechanism. It will also be a plus if very low income adults without children qualifying for SMP do not have to get vouchers every time they require medical assistance. This will be a particularly helpful change for FIA workers who spend a great deal of time taking calls and issuing these vouchers each month. Parents below the poverty level will also be saved considerable hassles if they do not have to prove they have met their spenddown monthly, which will probably result in more having access to Medicaid services because of the monthly time lines which often to not allow enough time to make use of Medicaid services once the spenddown is met.

Objectionable Changes

However, these plusses are offset by the requirements that services for SMP recipients or applicants would be cut back and co-pays required. There is also a questionable issue of whether after the first year, premiums will also be charged these groups. Adults receiving SMP with income below the current $264 cutoff usually have no income. How will they afford co-pays for their prescriptions or office visits? (The Department is reviewing all proposed copayments based on comments received from the public.) The only way many can possibly qualify for Medicaid or State Disability is through use of the vouchers to see doctors and get the necessary paperwork to qualify. Most are unemployed, sometimes homeless, and do not have the available funds to make co-payments. It also appears the single adults with incomes even slightly above the $264 a month would be ineligible for any coverage – even with a spenddown. These are people often working at low paying jobs for a limited number of hours, who are trying their best to maintain some kind of independence.

The same objectionable co-pays and limitation of services also appear to be in store for poor parents or caretaker relatives, and those with income even narrowly above the poverty level would not even have a chance to meet a spenddown. This is a cruel change.

It is sad that when the state had funds in the last few years to expand medical coverage to more people, particularly parents who are in low paying jobs without benefits, it did not do so.

Now we will hear about the financial pinch the state is in and the use of federal funds is the only way to provide some limited coverage for more people. Many other states have provided full Medicaid to parents even above 100% of poverty. Why has Michigan done so poorly in this regard, especially when we have fewer customers without private insurance than many other states.

To deny any chance of medical assistance to single individuals with income less than half of the poverty level is unconscionable. We often hear single women say that their friends who have had babies can qualify, but because they have not gone that route for whatever

reason, have no coverage even though they may be in much poorer health than their friends who have Medicaid.

I currently have Blue Cross Blue Shield Insurance because I graduated college and am gainfully employed *with the help of Medicaid.* As a single young mother, I needed the benefits of Medicaid's *complete* coverage to help deter costs so that I could better my life for myself and my son. Please do not take away this opportunity for others.

Please do not eliminiate the services proposed. ALSO, in my employment, I serve many low income people who would be devastated by these proposed cuts. I do agree with minimal co-payments. I believe this it is empowering for people to pay even just a small portion of their health care coverage.

The MIFamily Waiver is a step in the wrong direction and should be withdrawn. Instead of making the current Medicaid system more fair, more comprehensive, and less complicated,it makes the system, with a few minor exceptions, less fair, less comprehensive, and exceedingly more complicated. If there is additional money available to spend on Medicaid, such unspent federal dolllars from the MI Child program, why is DCH reducing benefits to the poorest of the poor in order to expand some coverages at the higher income levels?

For example, what possible justification is there for requiring copays for persons with incomes at the SDA level ($264.00) or for providing no coverage at all for those childless adults with incomes slightly over that level. This utter disregard for the hardships of our poorest citizens reminds one of Ebenezer Scrooge's comment that if the poor are unwilling to go to the poorhouse "then let them die and reduce the surplus population." If DCH was truly interested in utilizing extra dollars to improve the Medicaid system, it could start by raising the protected income level from the current ridiculously low level to 100% of the poverty level. Whoever wrote the HIFA waiver has obviously never had to explain to a elderly or severely disabled person with an income of $800 per month why she is not eligible for Medicaid until she incurs almost $400 in medical expenses each month. Even worse is trying to explain why someone with an income just slightly less than hers has full Medicaid coverage. I am certain that the bean counters at DCH have never had to explain why the spenddown system has to be so complicated--why it can't operate like a deducible.

There are numerous other examples of inequities in the current system that should be fixed, and could be fixed if DCH were so inclined, that could reduce the complexities of the current system and eliminate the numerous gaps that prevent many persons with incomes below 100% of the poverty from receiving comprehensive health care benefits. Simply stated, it is a sad commentary on our society that with our incredible wealth we cannot provide basic health care for those who have been left by the economic wayside. What ever happened to basic principal taught by the story of the Good Samaritan - that if a fellow human being needs help, and we can provide that help, then we should do so.

I want to commend the committee for working towards a waiver. I would like to suggest

1. that the time allowed for comment be extended considerably. This is policy that will effect the lives of people in a most important way.
2. we need to maximize federal funds
3. we need to maximize health care for uninsured, childless adults.
4. we need to expand health care for working persons with disabilities and for pregnant women.

I would appose
1.co-payments for peopler at 150% of poverty
2. co-payments that exceed $5
3. eliminating eyeglasses, dental work, home health and physical therapy services

I would encourage simplification of eligibility rules, which will in the long term pay for any flexibility in who is eligible and under what circumstances.

The Michigan County Social Services Association (MCSSA) is delighted that you have chosen to provide Medicaid coverage for additional low-income adults through an 1115 waiver. Expansion of Medicaid to families up to 100 percent of poverty has long been a legislative priority of the association since most low-income working adults are unable to secure health insurance through their employer, and are thus uninsured and unable to access necessary health care services. The proposed expansion of coverage will help low-income families achieve self-sufficiency since adequate health care is a linchpin to job retention, which is critical to self-sufficiency.

Additionally, we would like to commend the department for providing more continuous coverage for low-income children and for capturing additional federal funds to cover the cost of these expansions.

MCSSA does however, have several concerns as to the impact of the proposal as outlined in the public hearing. Those concerns are as follows:

- We are concerned that the proposed co-pays would act as a barrier to access to necessary health care, particularly preventative and routine care. Even a $5 co-pay for a family living below the poverty level is an enormous burden, and a $20 co-pay for an individual living at 35 percent of the poverty level represents almost of 1/3 of a week's income. Additionally, collection of co-pays is administratively time-consuming and labor-intensive and takes more resources than are recouped. We urge you to eliminate co-payments, and the potential for caps and premiums, for Medicaid recipients below 100 percent of poverty.
- A limited number of low-income families that have high medical care costs will be eliminated from coverage, since it appears that qualifying for Medicaid through

spend-down would no longer be available under this proposal. Low-income families currently under spend-down need continued Medicaid coverage.

- The benefits to parents and relative caregivers under Plan B represent a reduction in coverage from that currently available. The extreme poverty of families in this category makes the purchase of uncovered services unlikely. Additionally, the limitation for inpatient hospitalization under Plan C is troubling since it is unlikely that families between 51 and 100 percent of poverty would be able to cover hospital costs for stays in excess of 5 days. We are hopeful you will re-examine these plans and expand the proposal to provide coverage for all necessary health care services.
- Our last concern relates to the ability of Medicaid recipients to access covered services throughout the state. Efforts must be made by the department to insure there are adequate numbers of providers throughout the state to provide necessary care to Medicaid recipients.

MCSSA very much appreciates the efforts of the department to provide necessary health care coverage to this vulnerable population and would like to work with you to refine and implement the proposed expansion.

I am an individual concerned about upcoming Medicaid funding & structural changes. I would like to take this opportunity to express some personal comments about some of these proposed changes as it can drastically effect my family and myself.

My most recent experience with Medicaid comes from two very different areas of individuals in my family. First, I am a mother with a special needs child receiving Medicaid through Children's Special Health Care Services. Secondly, I am the legal guardian of my developmentally disabled adult brother who is well below the poverty level. While his overall functioning ability is 7 years 8 months old he has been turned down for Medicaid several times.

Michigan Legal Services has long advocated for the expansion of the state's medical programs to serve uninsured low-income Michigan residents. In the past, it has sued the state concerning co-payment requirements and the elimination of health care benefits for certain categories of destitute persons, and is currently challenging the state's poor participation rates in the EPSDT program for children ages infant to 21.

The Michigan Fair Budget Action Coalition has analyzed the state human services budget annually for the past decade and every year has advocated for the expansion of Medicaid and the state's medical programs to serve Michigan's low-income residents, on the theory that Michigan's budget priorities should reflect the fact that investment in health care and in our human resources in the state makes the greatest fiscal sense in the long-run

Michigan Welfare Rights Organization is a coalition of welfare rights organizations across the state which has advocated for comprehensive health care for Michigan's public

assistance recipients and other low-income residents who do not qualify for Michigan's increasingly restricted public assistance programs.

Westside Mothers Welfare Rights Organization is a membership organization comprised of public assistance recipients in Wayne County, which has advocated for the health care rights of its members for more than 30 years. It is currently a plaintiff in the case challenging the state's failure to adequately implement the EPSDT program.

The above-described advocates are concerned about a number of aspects of the proposed waiver requests which include the extremely short public comment period for consideration of these significant proposals which threaten the health care of 100,000 Michigan residents.

The advocates also wish to point out they support some of the waiver requests which will enable the state to maximize the use of federal funds in Michigan, provide continuous 12 month eligibility for Medicaid-eligible children, expand eligibility for some pregnant women and employed persons with disabilities, and streamline eligibility for some low-income adults.

Waiver Requests We Support

1. Maximizing the Use of Federal Funds For Health Care In Michigan.

The proposal to allow Michigan to use $487 million in federal SCHIP (State Childrens Health Initiative Project) money that would otherwise not be spent in Michigan because of Michigan's failure to enroll all of its uninsured SCHIP eligible children, makes sense, so that these funds previously committed to Michigan are spent for their intended purpose and Michigan can locate and insure these children. In addition, we support the request to permit Michigan to bring in an additional $400 million in other federal Medicaid and DSH (Disproportionate Share Hospital) funding for health care since it is unclear how much of this funding would be available to Michigan without the waiver.

2. Providing Continuous 12-Month Eligibility For Medicaid-Eligible Children.

Apparently the HIFA Plan will also guarantee that Medicaid would continue for 12 months for infants below 185% of poverty and children age 1-18 with incomes below 150% of poverty. Because this request would reduce gaps in health care coverage for these children, we support this request in the plan.

3. Providing new eligibility for some pregnant women and working persons with disabilities

We also support the provisions in the request which would expand full Medicaid coverage to pregnant women with incomes from 185-200% of the federal poverty level,

and cover a small number of certain employed former SSI recipients with disabilities with incomes up to 350% of poverty.

4. Streamlining eligibility for some low-income adults.

Finally, we support efforts to facilitate access to health care by eliminating bureaucratic barriers for childless adults below 35% of poverty who would not have to request written authorization from an FIA office every time they need to see a doctor, obtain a prescription or receive other basic services under the State Medical Program. For the same reason we endorse the proposal to eliminate cumbersome "spenddown" processes for parents with
incomes below 50-100% of the federal poverty level. Apparently individuals in these two groups would receive a regular monthly Medicaid card. However, their coverage would be further limited and they would have to meet co-payment requirements which we do not support in order to access basic services such as doctor visits or prescription drugs. In addition, DCH has indicated that these groups may have to pay premiums for their health care coverage next year and during the remaining four years of the waiver. These groups do not have the income to meet these additional co-pay and possible premium requirements and we therefore do not support these restrictions on access to health care.

Waiver Requests We Oppose.

We are concerned that these waiver requests will result in significant cuts in benefits and services to more than 100,000 adults who currently receive health coverage under Michigan's Medicaid and State Medical Program (SMP) programs and who are living well below the poverty line.

5. Parents and caretaker relatives with incomes between 50-100% of poverty.

For parents between 50-100% of poverty, it is not at all clear that the waiver request will promote better access to health care. Although the HIFA request eliminates the cumbersome spenddown process, it adds charges for co-pays for basic services and provides only limited coverage, including limited inpatient hospital coverage, home health services, EPSDT services for persons under age 21 and prescriptions.

6. Very Poor Parents Currently Receiving Medicaid Benefit lose coverage.

Under the proposed HIFA waiver, parents and kinship care providers (eg.. grandparents caring for grandchildren) currently receiving Medicaid because their income falls below Michigan's protected income levels (approximately 50% of poverty) would lose rights to certain types of medical services and coverage and would be charged a co-pay for many basic services such as doctor visits, dental care and prescriptions.

7. Low income parents who are Medicaid-eligible because of high medical expenses lose health coverage.

Parents and kinship care providers who are slightly above the poverty line but who have high medical expenses and who currently qualify for Medicaid would lose coverage under DCH's waiver proposal. These working poor parents and others on fixed incomes (such as Social Security) with high medical costs because of expensive health care needs are denied care altogether under the proposal. We cannot support depriving this low-income medically needy group the care they require.

8. Childless adults with incomes less than $264 per month are forced to pay co-payments in order to obtain basic medical care such as doctors visits and prescriptions.

This same issue was highly controversial nearly a decade ago when the state sought to implement a policy which would impose co-payments on destitute persons, effectively denying them access to basic health care (prescriptions and doctors visits). Advocates were told that former General Assistance recipients, struggling to survive without incomes, could "collect pop bottles" or 'give blood" to earn the co-pay for medical care! The proposal here recommends even higher co-pay amounts. A $10.00 co-pay for a single prescription would require the patient to collect 100 returnable bottles in order to see a doctor, and other 200 cans and bottles to pay for a prescription. Would the patient survive the payment efforts? The Department is reviewing all copayments based on comments received from the public.

9. Finally, very low-income childless adults with high medical expenses will lose coverage.

The proposal also targets extremely low-income (slightly above 35% of poverty) childless adults for elimination of benefits under the State Medical Program. Currently these individuals qualify for benefits as a result of spenddowns over a six-month period. The proposal here would remove coverage for these persons requiring medical care.

CONCLUSION

We urge you to reject the HIFA requests described at paragraphs 5-9 above which eliminate or reduce coverage for 100,000 very poor residents in Michigan who currently qualify for Medicaid benefits. At the same time we urge you to approve the proposal described in items 1- 4 above which would permit Michigan to spend committed SCHIP dollars, bring in additional federal Medicaid and DSH funding for health care, increase coverage for certain groups, and streamline the application process so long as the new co-pay and premium requirements described in Item 4 are removed.

General comments

We support the Department's effort to capture $330 million in federal SCHIP funds and to capture an additional $440 million in other federal Medicaid funds. We also wish to

support the plan to provide continuous coverage to Medicaid-eligible children and to childless adults in your Plan D group, and to expand coverage to certain pregnant women. Additionally, we are very pleased by the Department's statements at the February 4 forum that it is open to discussion about raising or eliminating asset limits for people who qualify for Medicaid under 1619(b) and that it is open to recommendations regarding asset limits for other Medicaid groups. Finally, we support the effort to eliminate the hardship of spend down for persons in your Plan C group.

There are, however, some portions of the proposal with which we disagree as they are presented in the few documents provided, and we remain worried about how all of this can be paid for without hurting some other current beneficiary group. We cannot support a program that extends benefits to some by reducing benefits to others, particularly as Michigan does not have an effective, cohesive health care policy on which to base such decisions. The result is an apparently arbitrary decision to reduce benefits to some groups while providing benefits to some new groups, without consideration to the health care effects on the group that suffers reduced benefits. Extending benefits to some while reducing them to others also raises the basic question of whether this program is truly an "expansion" of services to each group, which is a requirement of HIFA.

We are particularly worried that the reduced benefits for some groups in the HIFA waiver as proposed could have a disproportionate affect on people with disabilities, who are a high cost population for Medicaid and who use many "optional services" in order to maintain their health and to live full lives in the community. "Optional services" such as prescription drugs, rehabilitation therapies, durable medical devices, dental care and personal care services are critical to people with disabilities, and it is these services which are reduced for some Medicaid eligibility groups in the Department's proposal. Additionally, reducing "optional services" to any group also reduces preventive care. Prevention of secondary conditions for people with disabilities has been shown to be cost effective, and we are concerned that the Department's proposal may have long-term negative effects if preventive health is undercut.

While the Department's proposal does not change benefits for the Medicaid aged, blind and disabled eligibility groups, it would be a mistake to conclude that the individuals in your Plan B, C, and D groups do not have disabilities for which "optional services" are critical to independence and productive, healthy lives. Therefore, we cannot support proposals that put people with disabilities at a greater risk for loss of services.

Finally, we are concerned about the possibilities of enrollment caps and premiums in the future, both of which would diminish the effect of the "expansion" of health insurance to additional Michiganians.

1619(b) beneficiaries

While we do not oppose raising the income cap for Medicaid eligibility for individuals with disabilities who are working from $21,886 to $31,188, the cap is not the only barrier that keeps people on SSI and SSDI out of the work force. The existence of the $2,000

asset limit for 1619(b) beneficiaries means that a person with a disability who is working cannot build assets in any way as a hedge against an unexpected need to buy a wheelchair, for example, or to build savings to purchase a home. Imposing the asset limit keeps people forever in or on the edge of poverty.

- **We support eliminating the asset limits for people who get Medicaid through 1619(b).**

Additionally, as a member of the MI Job Coalition, UCP Michigan supports adoption in Michigan of a Medicaid Buy-In program that would permit working individuals with disabilities to "buy-in" to Medicaid. The Buy-In approach would be a more thorough, effective approach to moving individuals with disabilities who are able to work back into the work force.

Plan B beneficiaries

This group of individuals currently qualifies for Medicaid and receives the package of services that will be offered to your Plan A group. The benefits package to your Plan B group, then, is a reduction in services. Further, it imposes a copay on individuals who are already extremely poor. Copays for such extremely poor people accomplish only two things: they either keep people from utilizing medical care when they need it because they cannot afford the copay, or they place an added burden on the provider who cannot collect the copay. Either result is wrong.

- **We support restoring full Medicaid benefits to the Plan B group and eliminating the copays.**

- **Further, the Plan B group should be clearly defined to exclude parents who are ages 19 and 20, who should be included in the EPSDT category rather than the Plan B group.**

Plan C beneficiaries

This group of individuals will be relieved of the burden of spend down by the MIFamily proposal as it is covered in your chart, but group members will receive a reduced benefit rather than the complete Medicaid benefit package they now receive. This is particularly alarming in the case of the limit of $500 per day for the first 5 days of inpatient care. In addition, the copays for office visits and prescriptions are objectionable for the reasons stated above.

- **We oppose copays for the Plan C group and reduction of current benefits.**

Plan D beneficiaries

We support the aspect of MIFamily which would replace the State Medical Program with a continuous benefit for individuals in your Plan D group, except for the fact it provides a

reduced benefit and for the fact that it imposes copays. A plan that imposes $10 copays for office visits and prescriptions for individuals who by definition make no more than $264/month is not tenable. The copays for this group must be removed.

- **We oppose copays for Plan D beneficiaries.**

Beneficiaries losing all benefits

Some individuals would lose eligibility for all Medicaid benefits under MIFamily:

- Parents above 100% of FPL who are eligible for spend down would no longer be able to spend down and become eligible for Medicaid.
- Childless adults above 35% of FPL would no longer receive benefits of the State Medical Program.

- **We oppose loss of eligibility for any group in the absence of coherent health care policy**

The Michigan League for Human Services (MLHS) has long advocated expansion of Medicaid health coverage to a greater population of Michigan's low-income citizens. We want to encourage efforts to accomplish this goal. Efforts to provide twelve-month eligibility for children under Healthy Kids Medicaid, expand health care for uninsured, childless adults, and to expand health care for working persons with disabilities and pregnant women are applauded. We also are pleased that there is an effort to capture additional allocated but unclaimed federal dollars currently available.

However, MLHS does have significant concerns about the process. It is our opinion that there has been limited opportunity for input by consumers and advocates in the development of heath care policy and programs that affect low-income persons.

This concern is fueled by the extremely short time line for notice of this effort, limited notice of an introductory meeting for MIFamily, one week to submit comments coupled with the fact there is no written explanation of the program benefits, eligibility and financing.

Contrary to repeated assurances by MDCH staff that this waiver request would have **no effect** on current Medicaid recipients (except caretaker relatives), our review of the limited information available on the proposed MIFamily program shows that at a minimum:

- Eligibility for parents over 100 percent of federal poverty guidelines and 19-20 year olds over 35 percent of the same guidelines would be eliminated.
- Current health coverage for childless adults over 35% of federal poverty guidelines (the State Medical Program) would be eliminated.

This waiver request is for a five-year period. In the meeting on financing this proposal, held February 4th, the numbers orally presented were focused on FY 2003 and based on estimates that could not be fully explained by the speaker. MLHS is very concerned about the lack of adequate funding to pay for services or benefits that are part of coverage packages next fiscal year and the following four. There also seems to be no way to ensure that there will be an adequate pool of providers in all geographic areas of the state.

Further, questionable expansion funding adds to concerns about the current fiscal year's revenue short fall projected to impact funding to sustain current benefits to current recipients of Medicaid and the State Medical Program.

Therefore, MLHS opposes the above-described elimination of eligibility, and suggests a fuller examination of the proposed changes, coupled with additional meaningful public input. We are opposed to the proposed institution of co-payments, premium sharing, and other cost shifting to persons living below the poverty level. Adding this financial burden would in practical reality eliminate any utilization of the health care benefit. We further oppose the limited Medicaid benefits allowed to caretaker relatives as described at the February 4th meeting. This opposition is based upon our long held policy of not creating tiers of service, based upon some "worthy poor" standard.

MLHS strongly believes that all the citizens of Michigan would be better served by an open, full discussion leading to a comprehensive state health care policy reached by consensus and compromise, rather than what appears to be a questionable attempt to expand health coverage to some while eliminating coverage to others.

Please reconsider the economic calculations proposed in this waiver to minimize the number of low income persons who will be excluded or whose current health benefits will be reduced.
While the proposed waiver may have good intent, there are many low to moderate income persons who will suffer as a result in added co-payments and reductions in benefits. I think the proposal has a lot of potential and merit, but needs to address the concerns raised by the Center for Civil Justice.

As a preliminary matter we note that the comments contained in this letter are based on the very rudimentary information about the proposed HIFA waiver that was provided at the "forum" held by the Department on February 4, 2002 and in the press. We have many unanswered questions about the state's proposal that we submitted to state officials by e-mail on February 5, 2002.
In spite of assurances at the forum that questions from the public and Department answers to those questions would be posted on the department's or state's website, we have been unable to locate any posted "Q and A's". In addition, no answers were sent to us in advance of the comment deadline date of February 11, 2002. Some of the unanswered questions are referenced in our comments, below.

The Department also indicated that it would be available to meet with advocates who had questions or wished to discuss the proposal. However, when a meeting was requested on behalf of a coalition of several interested organizations and groups, the Department indicated that staff would not be available for a meeting to answer questions until February 19 – well after the comment deadline and only a little more than a week before the Department's self-imposed deadline for submitting the waiver request.

While we do appreciate the Department's willingness to accept comments, a 7-day period for public comment would be challenging in the best of situations. Here, where no complete, written explanation of the proposal has been made available and where very basic questions about the estimated number of individuals affected by the waiver (both positively and negatively) have not been answered, the comment period is wholly inadequate. This is particularly true in light of the Department's decision not to consult with advocates and those who would be affected by the waiver (*i.e.* Medicaid and State Medical Program recipients and uninsured adults including parents, pregnant women, persons who are elderly or have disabilities, and childless individuals) during the months in which the proposed waiver has been under development.

One of the many very basic and important questions that has not been answered is whether the Department intends to continue using its current methodologies for counting income of applicants under the various eligibility categories and programs that will be affected by the proposed HIFA plan. Our discussion below is based on the assumption that the Department will continue to use current income-budgeting methodologies for the various Medicaid categories and for the State Medical Program and that only the individual's budgeted income will be compared to the various percentages of poverty that are referenced in the documents distributed by the Department. In the event that this assumption is not correct, then the Department's proposal may well be considerably less helpful – and, indeed, significantly more harmful--to Michigan's low income adults than is reflected in these comments.

Use of SCHIP and other federal funds to provide health coverage to low income, uninsured adults in Michigan

We strongly support the Department's proposal to obtain a federal waiver in order to ensure that SCHIP funds allotted to Michigan will not go unused for health care in our state. We are concerned, however, that Michigan maintain its efforts to enroll all eligible children in SCHIP funded Health Kids and MIChild programs. It is our understanding that outreach efforts designed to ensure Healthy Kids and MIChild enrollment have been cut in Michigan due to recent budget shortfalls. We encourage the Department to ensure that all eligible children are enrolled in the Healthy Kids and MIChild programs. Only then should allotted funds be used to expand parent coverage.

Twelve months continuous coverage for children

We are pleased that the Department intends to provide uninterrupted coverage for low income children who are eligible for Healthy Kids Medicaid.

Efforts to expand health coverage for uninsured parents

We strongly encourage the Department's efforts to expand health care coverage to uninsured, low income parents. Specifically, we are very pleased that the Department proposes to eliminate spenddowns and extend full Medicaid eligibility to all parents who are living in poverty.

Use of SCHIP funds to assure coverage of the parents whose low income children qualify for Healthy Kids Medicaid and MIChild is an excellent use of the state's SCHIP allocation, as it is well-documented that children are more likely to be enrolled for health coverage if their parents also will be covered.[1] In addition, children are more likely to use health care services if parents also have access to care. Even when children have insurance coverage, they are almost three times more likely to visit a doctor during the year if at least one parent has also visited the doctor.[2]

Furthermore, it is clear that many parents who are leaving welfare for work are unable to access the medical care that they need to maintain good health. In a study commissioned by the Family Independence Agency and the Department of Career Development, one fourth of the parents who left welfare for work were uninsured. *Institute for Human Services Research, Report on Former Work First Participants: Fiscal Year 2001 (March 15, 2001).* Although about half of those who left welfare for work had jobs through which the employer offered some health insurance coverage, only 7% of the welfare 'leavers' had employers who paid the full cost of health insurance, and only 18-20% had employers who would pay at least part of the cost of insurance.

When uninsured, low income parents become ill or suffer injuries for which they are unable to access medical treatment, they cannot earn enough to provide a healthful environment for their children, including nutritious foods and safe, suitable housing. In many instances, families must turn (or return) to the Family Independence Program cash assistance rolls in order to avoid disaster. Alternatively, parents living below poverty level are forced to use scarce resources to pay for medical care, leaving insufficient funds to purchase food or pay their rent and utility bills, placing the family in jeopardy of homelessness or malnutrition. Clearly, the health of the parents is pivotal in ensuring the health and well-being of the entire family.

We therefore support efforts to expand Medicaid coverage to parents who are below 100% of poverty, which will place them on parity with individuals below 100% of poverty who are elderly or have disabilities and thus are eligible for health coverage under Michigan's ADCare Medicaid category.

However, while we generally support expanded coverage for parents, we have serious reservations as to whether the Department's proposed HIFA plan will significantly

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[1] Ku, Leighton and Mathew Broaddus, "The Importance of Family-Based Insurance," Center on Budget and Policy Priorities, September 2000, found that coverage of young low-income children increased five times more (16% v. 3%) in states with broad expansion that included parents than in states that did not expand to parents.

[2] Hanson, Karla, "Is Insurance for Children Enough? The Link Between Parents and Children's Health Care Revisited," *Inquiry* 35 (Fall 1998) 294-302.

increase access to medical care for any significant number of parents, as discussed below. We also are gravely concerned about the reduction in access to medically necessary services that the state intends to impose on very poor parents as well as childless adults as part of its HIFA plan, as also discussed below.

Streamlined eligibility for services under the State Medical Program
We support plans to allow State Medical Program recipients to access health care without obtaining prior authorization from a Family Independence Agency (FIA) caseworker. However, other proposed changes in the State Medical Program (SMP) would make health care completely inaccessible for the childless adults living below 35% of poverty who make up the SMP-eligible group under the proposed HIFA plan, as discussed below.

Efforts to improve maternal health
We support efforts to improve maternal health and the health of every child born in Michigan. However, we are very concerned that an expansion of the full package of

Medicaid coverage to pregnant women between 185 and 200% of poverty may benefit only a very small number of women[3] less helpful in improving maternal health and reducing infant mortality than efforts to expand health care access that would improve the pre-conception health of women with much lower incomes.

As discussed in more detail below, we are very concerned that Michigan's HIFA proposal will severely restrict access to health care for childless adults (including women in their child-bearing years) and for parents who currently qualify for Medicaid because their income is below 50% of poverty (many of whom are women who will become pregnant again).

We believe that this an area that deserves further study in order to identify an approach that makes the best use of state and federal funds for health care to improve maternal and infant health.

Health insurance for persons with disabilities entering the workforce
While we support efforts to make affordable health care available to low income persons with disabilities, including those who are striving to work despite disabling conditions, we are concerned that the proposed extension of 1619(b) coverage will not target those persons with disabilities who are most in need of health care coverage and least able to afford it. I understand that many advocates for persons with disabilities have been working to engage the Department and the legislature in discussions that could result in the development of a Medicaid buy in program for persons with disabilities who have earnings. We would encourage the Department to engage in meaningful discussions with these very knowledgeable advocacy groups in order to design an expansion for disabled workers that will most effectively utilize Michigan's scarce health care dollars.

Elimination of coverage for low income parents with high medical expenses

[3] It is unclear what the Department's estimate of 2,000 recipients in this category is based upon.

The proposed elimination of 'spenddown' Medicaid eligibility for the Group 2 (medically needy) caretaker relatives whose income are above poverty but whose medical expenses decrease their disposable income to less than roughly 50% of poverty[4] is unacceptable. Crushing medical debt can prevent low income parents from ever achieving self-sufficiency, as they will struggle to increase their earnings only to find that those earnings must be used not to improve the lives of their families but instead to pay off medical debts.

Among our unanswered questions about the proposed HIFA waiver is how many needy caretakers will be affected by the proposed elimination of spenddown eligibility and the estimated cost savings from this element of the HIFA proposal.

Coverage for 19-20 year olds

When asked whether Medicaid eligibility would continue for medically needy persons under age 21 if the HIFA waiver were granted, the Department was unable to give an answer at the forum held on February 4, 2002. To date, emails posing this question have not been answered, either. Medicaid coverage for the Under 21 eligibility category are unaffected by the proposed waiver.

It is our understanding that about 44,000 young people receive Medicaid coverage under this eligibility group each month.

We strongly oppose any effort to eliminate Medicaid eligibility for this group of young persons.[5] Failure to provide health care coverage to the young women in this category is likely to have a negative impact on maternal health for those who later become pregnant.

Elimination of eligibility for these young persons also is likely to have a negative impact on their ability to pursue and complete education and training that will enable them to obtain higher wages jobs with employer-provided health insurance coverage – and thus will tend to promote dependency and a need for higher spending on social welfare programs in the future.

Michigan should not decrease its investment in the health of these 44,000 young people.

Coverage for kinship care providers

It is not clear from all of the written materials distributed by the Department whether or not caretaker relatives will be included in all of the HIFA "Plans" that cover parents.[6] We would oppose any effort to eliminate coverage to caretaker relatives, given the

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[4] The income test is, of course, the Protected Income Limit which varies from county to county. The 50% of poverty level is used as only a rough estimate of the PIL.

[5] Under the HIFA proposal, it appears that young persons would lose the full medicaid package of services and would instead have to qualify either as a person under 35% of poverty who could receive only the limited SMP benefit with high co-payments, or as a caretaker relative or pregnant woman.

[6] While some written materials prepared by the Department include non-parent caretaker relatives, others refer only to parents.

important role that they play in reducing foster care placements and expenditure and in maximizing the chances that children whose parents are unable to provide care for them will develop into healthy productive citizens.[7]

Cost sharing for parents and care taker relatives

We strongly oppose efforts to impose increased cost-sharing, including co-payments or premiums, on parents or other caretakers who are living below 100% of poverty. These adults are, by definition, unable to afford cost-sharing. Many of these adults have health problems that require periodic visits to specialists as well a their primary care provider, and may be taking several different prescription drugs in order to control chronic conditions and maintain their ability to work in order to support their family.

It is well-documented that the imposition of cost-sharing not only discourages individuals from seeking medical care, but also -- when applied to persons living on poverty -- has a negative impact on health.[8]

We at the Center frequently receive telephone calls from adults who are not eligible to enroll in managed care plans and who are struggling to afford even the $1 or $2 per prescription co-payment that currently is imposed on fee-for-service Medicaid recipients.

These adults end up skipping doses or not filling prescriptions because of co-payments, or paying for co-payments and reducing their spending on other, subsistence needs such as food. In either scenario, their health is severely compromised.

Clearly the Department should not be imposing additional and higher co-payments on persons living in poverty.

Cost sharing for "childless adults"[9]

Adults living on incomes below 35% of poverty or $264 per month simply cannot afford to make co-payments of $10 per office visit and $10 - $20 per prescription.[10] While the Department's proposal purports to replace the existing State Medical Program (SMP)

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[7] We also would oppose any waiver that would perpetuate Michigan's practice of budgeting income for these non-parent caretaker relatives without using the pro-rating methodology that takes into account the needs of the children in their care in the same manner as the needs of children are considered when determining a parent caretaker's Medicaid eligibility.

[8] See Park, Edwin and Ku, Leighton, "Administration Medicaid and SCHIP Waiver Policy Encourages States to Scale Back Benefits Significantly and Increase Cost Sharing for Low-Income Beneficiaries" (Center on Budget and Policy Priorities August 15, 2001), citing R. Brook *et al*. "Does free care improve adults' health? Results from a randomized controlled trial," *New England Journal of Medicine*,309(23):1426-34, Dec. 8, 1983; E.Keeler, *et al*. "How free care reduced hypertension in the health insurance experiment," *Journal of the American Medical Association*, 254(14):1926-31, Oct. 11, 1985; N. Lurie, *et al*. "How free care improved vision in the health care experiment," *American Journal of Public Health*, 79(5):640-2, May 1989.

[9] Some of these "childless" adults are, in fact, non-custodial parents who need health care in order to be able to provide some level of financial support for their children.

[10] The Department has not clearly indicated whether it intends to maintain the current income limits for an eligible couple under the SMP program. We would oppose any effort to reduce the level to 35% of poverty – it should be maintained at the current, 41% level.

with a new Medicaid eligibility group, the effect of imposing cost-sharing on this group of very low income persons is to eliminate their access to health coverage.

Imposing cost-sharing on the SMP-eligible population simply is unacceptable as it will completely destroy access to health care for this very vulnerable and very poor population.[11]

Coverage for childless adults with medical expenses and with incomes slightly above 35% of poverty

Currently, a small number of persons qualify for SMP coverage by meeting a spenddown. This coverage can be essential to low income, childless individuals whose income is slightly above the SMP income limits but who have significant, ongoing medical expenses that must be met each month.

Spenddown eligibility for childless adults should not be eliminated unless it is replaced with an alternative that does not diminish access to care for the very low income persons who have used it under the SMP.

Covered services for parents should not be reduced

We strongly oppose the Department's proposal to drastically reduce the medical services covered by Medicaid for low income parents living below poverty. Many of these parents are the "working poor" who cannot be productive citizens and provide care and support for their children unless they can access medically necessary services. One need only glance at the list of eliminated and limited services to realize that a parent who needs but cannot obtain these services will be severely limited in their ability to work and to care for a family.

We strongly oppose plans to eliminate the following services:

- Eyeglasses
- Dentures
- Prosthetics/Orthotics
- Physical therapy
- Occupational therapy
- Treatment of speech, hearing, & language disorders, such as hearing aids and hearing & speech center services
- Diagnostic services
- Rehabilitative services
- Podiatrist services
- Optometrist services
- Chiropractor services
- Nursing facilities
- Transportation
- Case management
- Respiratory care
- Personal care

[11] Furthermore, if provider are forced to provide services to participants who cannot afford the co-payments, as required under federal Medicaid law, it is unlikely that even those few providers who accept SMP would participate in the HIFA plan for this group.

- Intermediate care facilities for the mentally retarded
- Inpatient Psychiatric or Nursing Facility care for persons under 21
- Rural
- Health Center & Federally Qualified Health Center services

We also strongly oppose proposed reductions in the following services for those at :

- Inpatient hospital coverage limited to a $500 per diem payment for the first 5 days of inpatient care for those between 50 and 100% of poverty
- Home health services limited for all
- Early Periodic Screening Diagnosis and Treatment services for persons under 21 limited for all
- Prescriptions[12] limited for all

Other issues

Public input and availability of information

As indicated above, we appreciate the opportunity to provide input but we feel that this opportunity would be much more valuable – both for members of the public and for the Department – if additional time and information were available.

The issues involved are complex and the ability to provide thoughtful input depends on the availability of information about the costs and savings associated with various aspects of the waiver, the number of persons affected, the historical usage and cost of various services, etc.

We strongly encourage you to extend your self-imposed deadline for submitting the waiver request, provide the information and answers requested by advocates, and engage in a meaningful discussion of these issue with affected consumers and interested advocates.

Adequate, sustained investment in health care

We are very concerned that the Department has not fully explained the assumptions that underlie the waiver proposal. For example, it appears that the very significant reductions in access to health care that will result from the elimination or reduction of covered services, the imposition of cost sharing, and the elimination of eligibility for certain individuals will result in large savings to the state -- as will the use of federal funds to defray the cost of some coverage currently funded either without federal funds or at a lower match rate than the SCHIP rate, and the increased use of county funds. Nevertheless, the Department has not shared information about the full cost savings, so that interested organizations can knowledgeably assess the funds that may be available to expand services to other populations. In addition, it is unclear how the department has estimated the number of individuals who will be covered and what the cost will be of the

[12] DCH summary indicates that there would be a limited formulary of drugs for these limited benefit Medicaid recipients.

proposed eligibility and coverage for adults under the so-called Plans A and C.[13] Without this information, it is difficult to determine whether the state is maintaining its investment in health care for low income persons in Michigan.

We believe that it is critical for the state to maintain this investment in order to ensure the productivity of all of its citizens.

In addition, it is not clear whether the state proposes to spend a sufficient amount on contracts with providers to ensure that a sufficient number of providers provide care to the various groups of individuals whom the state proposes to cover under the waiver, particularly in rural areas and other "problem" areas where access to health care is particularly problematic for recipients of governmental health coverage.

Conclusion

We hope that the Department will postpone its application, and take this opportunity to open a dialogue with affected consumers and interested advocates, in order to work together toward the most beneficial use of federal funds that may be accessed through a HIFA waiver. We look forward to working with you in such an endeavor.

Over the past four years, the Michigan Poverty Law Program (MPLP) has been a strong advocate for expanding the Medicaid program. MPLP has encouraged the legislature to raise the income limits and simplify the Medicaid program in order to provide expanded coverage to low income working adults. The goal was to increase the number of people that would be able to access health care coverage without sacrificing the needs of other populations and without an increase in cost-sharing. The current MiFamily 1115 Waiver Application proposal, while it does expand the number of persons that would be eligible for coverage, also cuts services to current beneficiaries that will continue to need health care. Although MPLP commends the Governor for attempting to expand Medicaid coverage, it cannot support a waiver that appears to arbitrarily deny health insurance to currently eligible groups.

MPLP is a member of the Coalition for Fairness in Health Policy. This coalition has made ongoing requests from the Department of Community Health over the past several months about the current waiver proposal . It had been told that no waiver was being sought in Michigan. Now that the waiver has been proposed and appears to be on a fast

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[13] According to Denise Holmes' answers on February 4, 2002, Plan B covers a group of parents who already are eligible for Medicaid (35,000 current recipients) whose coverage will be cut, not expanded. Plan D appears to consist of the 50,000 current State Medical Program recipients, who will have almost the same package of covered services (except for podiatry) but will have large co-payments.

The Department has previously indicated in filings with the courts that only 30,000 parents currently have spenddown Medicaid in Michigan. Thus, it is unclear how the state estimates that Plan C would extend coverage to 80,000 additional parents. The state also has not disclosed what type or "take up" rate it has assumed in reaching its estimates of eligible persons and costs of expanded coverage.

track, the Coalition as well as all other advocacy groups are being rushed to evaluate the proposal and make comments. There are still numerous questions about the program and its budget that have not been answered. It is not possible to make a complete evaluation when important information has not been disclosed to the public. We have concerns about a process in which the effected groups are initially not consulted and then given very little information about the product.

CONCERNS

Elimination of eligibility for health care coverage (currently State Medical Program) for childless adults over 35% of poverty as well as implementation of co-pays for medical services. Individuals that are existing at 35% of poverty, or $264.00 per month, would be effectively precluded from obtaining health care if co-payments are required. Although a $10.00 or $25.00 co-pay may not seem excessive in theory, in practice it represents 5-10% of an individual's monthly income. These co-pays would inhibit routine doctor visits and thwart the overall goal of having a healthier population, especially for people who are already at a higher risk of illness because of inadequate nutrition and substandard housing due to poverty. If parents are discouraged from obtaining health care, studies have shown that they will also be less likely to obtain medical care for their children.

Limited Medicaid coverage for Caretaker Relatives. The services being proposed under Plan B would unfairly reduce the current coverage for this population. Parents and caretaker relatives that fall into this category will continue to need coverage and will not be able to afford to purchase medical insurance as proposed. Although the current spend-down system is both confusing and time-consuming, its elimination would leave parents with income above 100% of poverty with no Medicaid coverage. Medicaid expansion to currently ineligible groups should not be at the expense of populations that are currently eligible and have a continuing need for access to health care.

For the reasons listed above as well as others not enumerated here, the Michigan Poverty Law Program is opposed to the proposed MiFamily HIFA waiver application. There are positive aspects of the proposal, such as efficiently utilizing federal funding, expanding coverage to the working disabled and 12-month eligibility for children covered by Healthy Kids Medicaid. However, we believe that any successful expansion of the current Medicaid system will only result from a process that is inclusive and considerate of the needs of its constituents. We encourage the Department to engage in an open dialogue with the populations effected as well as their representative groups before submitting the current proposal.

The Michigan Developmental Disabilities Council (council) appreciates the opportunity to provide comments on the refinement of the HIFA waiver the department is considering submitting to CMS. There is disappointment that this comment period is limited to only

one week for input. This will significantly restrict direct comments from the constituents most impacted by the proposed changes. This is an opportunity to increase some level of protection to residents, but there is the downside in a few areas where the council wishes to express concerns.

We acknowledge your comments that this HIFA waiver is not a Superwaiver, but rather an additional waiver which will enable the department to capture additional Medicaid funding, but must remain cost allotment neutral to the federal government. The program is anticipating being funded primarily by uncaptured SCHIP funds.

The department indicated that this cost neutral HIFA waiver will not affect other waivers and services under those waivers currently in place utilized by persons with disabilities.

There is a concern regarding the level of assets the department is permitting. There is a $2,000 asset limit with a suggested investment offset into a retirement account. The council feels that the offsets should be broader to permit individuals to have something to show for their returning to work, particularly in the 1619 areas. Broader asset limits, still permitting Medicaid eligibility, should include costs, or savings accounts dedicated or attributable to essential to food, clothing, shelter, assistive technology and transportation. Assistive technology would include items essential to environmental controls, communication, personal assistance, medication reminder or health regimen. The council views these items as a means to increase independence, productivity and quality of life. A down payment for a home could be saved!

The Caretaker Relative group becomes eligible for fewer benefits under the proposal. Although the new waiver category will more than double the income limits and provide coverage to 100% of the FPL for parents and those acting as parents, the benefits will not be as substantial as those currently provided. In the cases where elderly caretakers are providing supports for their children, (about 60% of adult persons with disabilities are living at home with their elderly caregiver) there are great numbers of persons with disabilities at risk if parents cannot receive needed care. With persons between 51% to 100% of FPL, what happens after five days of hospital care? The proposed benefit pays a per diem rate for the first 5 days of inpatient care. If a person were to stay longer than five days the hospital would make the same arrangements for payment as currently occurs for persons in this income group who have no insurance coverage. If the Caretaker Relative group do not receive adequate timely care, the dependents will become a greater cost liability to the state. We encourage the benefits to remain the same as today's benefits for Caretaker Relatives below 50% of FPL, but eliminate spend-downs that are administrative and consumer unfriendly. The families between 51% and 100% should have the emergency room co-pay costs for improper use, but clinics might be considered in areas where people could go when they cannot get into a doctor's office. The 51% to 100% group may have co-pays considered by gross income, but also be kept low enough so doctors' offices may write off the co-pay if they wish. This proposal permits family members to support family unity, when that is their choice. This saves money to the system in the long run by reducing other requested services.

There is concern regarding co-pays for any low income group of individuals. Those with the most limited incomes must provide the greatest proportion of co-pay relative to their income. This means these individuals may need to choose between food, shelter, doctor visits or medicine. We suggest that the plan reduce the co-pay for these individuals, or provide other cost savings. One type of cost-saving would be to have maintenance medications be purchased through the mail in three-month supplies, thus saving paperwork and transactions.

There is a lot of promise to improving health care to Michigan residents, but the process is moving so fast that we are not able to meet with the department and discuss remedies that can save funds and cover more people in need of medical care.

Two or three focus groups in the next two weeks would greatly improve the opportunity to improve the system fairly and create win-win circumstances without stopping this opportunity for the HIFA waiver.

These comments are presented on behalf of the MARO Board of Directors. MARO consists of Michigan organizations that provide employment and training programs for people with special obstacles to employment. Many MARO-affiliated organizations provide services to Medicaid populations through contracts with Community Mental Health Boards.

The HIFA Waiver sounds like a wonderful opportunity to expand Medicaid coverage to many more people at risk.

Like many other groups, MARO's concerns are that this not be done at the expense of services for current mental health populations. At the Forum on February 4, there were multiple assurances that this would not be thecase, that the new waiver would not reduce mental health services for either current Medicaid or nonMedicaid mental health recipients.

Subsequent to the Forum, the Michigan Community Mental Health Board Association formulated a number of questions that presented this concern in more detail.

The MARO Board of Directors affirms the questions submitted by the CMH Board Association. We believe answers to those questions are essential before our membership can have an informed opinion on this topic. When you respond to the CMH Board Association questions, please also mail a copy of your response to Dave Price, MARO, 417 Seymour Ave. Suite 5, Lansing, MI 48933. The CMH Board Association is aware of our request and our support for the questions they have put together.

In addition, as an employment organization, we are very interested in the provisions that would allow persons with disabilities receiving SSI to earn up to $31,188 a year without losing their Medicaid benefits.

Our questions in this area are:
*does this extend to people receiving both SSI and SSDI? The current proposal would only provide the higher earning cap to people on SSI.
*what are the obstacles to extending this to people with SSDI? Many on SSDI are not currently eligible for Medicaid. Extending the higher earning limit to SSDI would create new Medicaid costs that could not be covered under the waiver and maintain the required federal budget neutrality.

Plan D benefits make little or no sense. The income of SDA and /or SMP recipients is insufficient to pay monthly rental expenses, let alone $10 co-pays for prescriptions, doctor visits, and testing. Requiring such a co-pay for those individuals is tantamount to canceling their medical insurance. Based on comments received from the public, the Department is reviewing all of the copayments included in the original draft of the proposal.

Additionally, since this category of individuals is the one for whom assistance for work readiness is greatest, the proposed changes in coverage would eliminate one of the most important means of assistance.

The HIFA proposal, as described in the public meeting on February 4th and in the recent press release, will affect Michigan citizens with disabilities in a number of ways.

We applaud the capture of significant amounts of new federal funding through the use of SCHIP money that would otherwise not be spent in Michigan, particularly at a time of state revenue shortfalls. In addition the proposal to provide some childless adults a regular Medicaid card on a monthly basis would streamline access to health care and prescriptions.

Since multiple sclerosis is an adult on-set chronic disease the vast majority impacted by decreased income earning capacity simultaneous with high medical costs are adults without minor children. It appears that in the HIFA proposal childless adults will lose access because of co-payments and the elimination of coverage when they have high medical expenses.

Section 1619 (b) as entry to Medicaid
We appreciate the attempt to expand health coverage for people with disabilities who want to work and fear the loss of health care. However, the population group covered by this initiative--those SSI recipients currently eligible for Medicaid under Section 1619 (b) omits the large numbers of people with MS. The episodic nature of the disease makes it very difficulty to establish permanent disability status. Lose of income and high periodic medical costs occur long before disability status can be established for many. The Section 1619 (b) provision would give very few people with MS access to Medicaid.

While the HIFA proposal would allow section 1619 (b) participants to increase incomes to 350% of FPL and to save for retirement, the basic $2,000 limitation on accumulation of other assets makes it almost impossible for individuals to gain any degree of self-sufficiency.
People with disabilities will be unable to save for things such as vehicle purchase or repair necessary to maintain their employment.
In addition they would be unable to pay emergency health care costs not covered by Medicaid; nor to make home modifications required by their disability.

In addition access to Section 1619(b) is extremely problematic even according to SSA senior management. For the state to hinge Medicaid for persons with disabilities to a SSA program that isn't working is a false promise. In addition there is no plan to address the 1610 (b) access problems and the state is not accountability to improve the situation.

Copays
Establishment of copays for severely low-income individuals could decrease rather than increase health care access. This will increase the possibility of an additional disincentive for providers when they will be focused to adsorb the loss if they treat individuals who can't pay the copay and could lead to the loss of providers. Thus more individuals could be focused to emergency room "treatment" due to lack of an available provider.

Childless Adults
Currently some low income childless adults with MS quality for the State Medial Program because their medical expenses are excessively high in a short period. The sporadic nature of MS can greatly delay both a definitive diagnosis and confirmation of disability status. During this period income is lost and medical costs escalate especially if the disease goes untreated. Thus the elimination of health coverage for childless adults over 35% of federal poverty guidelines (the State Medical Program) is likely to increase the number of required hospitalizations, thus increase the cost of Medicaid medical services and reduce any possible earning power the person with MS might otherwise have had. A similar situation exists for persons with other chronic illness.

The National Multiple Sclerosis Society, Michigan Chapter is a member of the Coalition for Fairness in Health Policy, and has endorsed the Coalition's stand regarding any Section 1115 waiver for the State of Michigan. Most notably, we shares in the belief that such a waiver needs to:

- Ensure access to necessary health care services for Michigan residents, not just increase the number of persons who are labeled as insured.
- Be consistent with health care priorities and a cohesive health care policy.
- Developed in consultation with representatives from the groups of Michigan residents who will be affected by the plan

The March of Dimes commends state authorities for seeking input in the development of this initiative from many of the stakeholders who have an interest in these vital health

programs. We appreciate this opportunity to provide initial reactions to your proposed HIFA waiver submission.

Although much of the detail is still being developed, I am particularly pleased to see a commitment to maintaining the safety net for children and pregnant women outlined in your draft waiver documents.
In addition, the state's intention to expand coverage of pregnant women from the current level of 185% of poverty to 200% of poverty is a significant step toward eliminating the number of uninsured pregnant women in Michigan. According to Census Bureau data prepared for the March of Dimes, there were 281,000 (or 13%) women of childbearing age without health insurance in Michigan in 2000. Many of these women will become pregnant. According to the state's proposal, this expansion will provide an additional 2,000 pregnant women with access to Medicaid: clearly, a step in the right direction. As you continue to develop your proposal, I would encourage you to clarify that first time pregnant women will be eligible for coverage under MIFamily. We know prenatal care improves birth outcomes and can save money. According to the National Center for Health Statistics, infants born to mothers who receive no prenatal care or late prenatal care are nearly twice as likely to be low birth-weight. In fact, low birth-weight accounts for 10% of all health care costs for children.

I strongly encourage you to eliminate cost sharing requirements for pregnant women particularly those for prescribed drugs and dental benefits. No disincentive should be imposed on pregnant women who might not seek prenatal care during pregnancy. There is also some evidence – although limited – that poor oral health may lead to premature births or other pregnancy related complications. While cost sharing can serve to dissuade patients from inappropriately using services (e.g. the emergency room), cost sharing can also discourage patients, particularly those with limited incomes from using the services they need.

I am particularly pleased to see that the proposal would also provide "continuous eligibility" to children covered under Healthy Kids. Continuity of care is one of the most serious problems families face in the Medicaid and SCHIP programs.

According to a news release issued by James K. Haveman, Jr., Michigan Department of Community Health Director on Jan. 31, 2002, MIFamily proposes to expand coverage to "parents and persons acting as a parent living in families with incomes between 51% and 100% of poverty." Raising eligibility for parents – now limited to those with incomes below 50% of poverty – will reportedly provide access to coverage for an additional 80,000 parents of children now enrolled in Medicaid. The March of Dimes is concerned, however, that the proposal limits the scope of benefits for these individuals and imposes new cost sharing requirements, which may mean beneficiaries won't use the services they need.

The time allowed for public comment has been altogether too short to enable a thorough analysis of this complex Health Insurance Flexibility Waiver and its impact

on individuals and agencies. We support your efforts to make full use of federal funds the provisions for 12 month eligibility, and the expansion of health care for working persons with disabilities and for pregnant women.

It appears, however, that the proposal disadvantages Plan B recipients currently under Medicaid by requiring co-pay and reducing benefits, that neither MIChild nor Plan D cover 19 and 20 year olds (19 and 20 year olds are covered through the Under 21 Medicaid category that is not included in the proposed waiver.), that Plan D by not providing an inpatient hospital benefit and requiring co-pays is no improvement over existing arrangements, and that parents over 100% FPL currently covered under spend down provisions will now not have that option.

Further it appears that the funding arrangements will come at the expense of reduced reimbursements for providers who cannot collect co-pays, and with the loss of flexibility in services currently available to the county health plans and to community mental health entities.

We are encouraged to see efforts to provide insurance to uninsured Michigan residents, and efforts to capture federal dollars. However the number of unanswered questions about the waiver coupled with the short time for comment, lack of written materials and refusal of the department—despite an invitation to the group--to meet with members of the Coalition for Fairness in Health Policy prior to the comment deadline raise serious doubts about the department's commitment to public input. The repeated statements by DCH officials over the past many months that it did not intend to pursue a waiver only adds to those doubts. As a preliminary comment, the Association is deeply concerned about the lack of information surrounding the waiver available to the public. The format of my comments includes many questions along with comments necessitated by the lack of answers to questions raised by advocates. (I am incorporating the questions submitted to David Viele by the Coalition for Fairness in Health Policy on February 7, 2002.)

The submission of this waiver should have been an occasion for a public discussion about a public health policy in Michigan; instead we have been presented with the outline of a waiver package that includes underlying assumptions for which a rationale has not been provided.

Policy considerations

…While we are supportive of efforts to expand maternal health care, we wonder what policy supports the decision to provide a full array of benefits to certain groups up to 200% of poverty, but to severely reduce the benefit package to poor working parents. What policy rationale supports the decision to exclude working parents/caretaker relatives above 100% of poverty, previously allowed to spend-down to gain eligibility, from Medicaid benefits altogether. The department believes that providing continuous coverage to those under 100% of the federal poverty level is a better policy than providing sporadic coverage to higher income individuals. The HIFA proposal must be

budget neutral to the federal government. Budget neutrality requires savings in one area to expand coverage in another.

Why are the poorest Michigan residents going to assume the largest co-payments making the benefit essentially illusory unless providers routinely waive the co-payment. What are the policy assumptions behind this decision—is the purpose to deter utilization by this group. Is Michigan seeking waiver of the Medicaid provision that prevents denial of services to individuals who cannot afford copayments; if so, what purpose is served by that. Based on public comment, the Department is reviewing all copayments for appropriateness.

What factors went into determination of reduced benefits package or limited services to certain groups; what data is available showing utilization of a particular service—does high utilization lead to elimination of a service. The benefit packages were developed in consultation with the Department's actuaries and are intended to provide the basic benefits required by the population being served.
What justifies eliminating so many services to parents, including for example, elderly caretaker relatives, under Plans B and C? Elderly (presumably over persons over 65) are covered to 100% of the federal poverty level under the AD Care eligibility group. AD Care benefits are unaffected by the proposed waiver.

How do we know that these changes will improve the already relatively poor health status of Medicaid-eligible Michigan residents? The provision of high quality, basic health services will improve the health status of the covered population. Parents and those acting as parents who are under 100% of the federal poverty level will have access to primary care, pharmacy, outpatient care and other services on a continuous basis that will allow them to maintain an improved health status while avoiding more serious, preventable health problems.

What is the policy behind and how can the department legally provide a limited package of benefits to EPSDT-eligible 19 and 20 year-olds. (The Under 21 category of Medicaid eligibility is unaffected by the waiver. The benefits under the MIFamily coverages include preventive services based on the American Academy of Pediatrics Periodicity Schedule to ensure that persons under 21, who chose this eligibility category, maintain access to these services.) We are also concerned about continued Medicaid eligibility for medically needy 19 and 20 year olds; the department was unable to answer this question at the public hearing on February 4, 2002. As noted above, the Under 21 category is unaffected by the waiver proposal.

What led the department to limit inpatient care to 5 days for parents/caretaker relatives between 51% and 100% of poverty? (The Department limited the inpatient benefit to reduce costs to allow more people to be covered under the program. In addition, the parent group is generally healthy and does not use a great deal of inpatient care.) What is the impact on county hospital programs, i.e. Wayne County? County programs are free to supplement the basic benefit package.

The department stated, in response to questioning, that it was reserving the right in the waiver request to impose enrollment caps and premiums on certain groups in future years. What criteria will be used to make these decisions; have decisions already been made about these restrictions. The waiver proposal will include provisions for an annual, public process to review eligibility and benefits under the waiver. In future years, the state may find it necessary to limit benefits, establish premiums for certain coverages or to cap enrollments. It may also be able to expand eligibility or benefits and reduce copayments. The criteria used will include revenues available to support the program and the priorities of the current administration. No decisions related to future years have been made—other than to keep options open so that the best decisions can be made.

The Association opposes the elimination of coverage for parents/caretaker relatives above 100% of poverty and the substantial retrenchment in benefits and services the waiver represents for many groups of beneficiaries. The Association opposes the imposition of copayments as it is known that copayments of as little as $1 or $2 act as a barrier to health care. We oppose imposition of premiums and enrollment caps; we have received no information as to what criteria would be used to make decisions on use of these restrictions. The Association opposes any reduction in services and benefits to children below 21. We support the plan to maintain 12 months eligibility for children in the Medicaid and MIChild programs, however we point out that children receiving benefits under the MIChild program who fall below 150% of poverty are entitled to receive the full package of Medicaid benefits immediately; they should not be kept in the MIChild program where they receive fewer benefits.

Financing and budgeting questions and concerns

We are encouraged by the department's efforts to realize $888 additional federal dollars, however we have many unanswered questions about the assumptions that go into that figure. We incorporate the budget questions already sent to you by Jackie Doig and by the Coalition for Fairness in Health Policy. Those questions have not been answered and I have some additional questions.

What savings are assumed by streamlining certain aspects of the MIChild program and what is that streamlining? The Department is reviewing the cost of the current delivery system for MIChild services to see if there are potential cost savings in providing services through HMOs rather than PPOs. This analysis is not complete at this time.

What savings are anticipated by reducing benefits to 19 and 20 year olds. There are no modifications to the Under 21 category proposed in the HIFA waiver.

What savings are anticipated by imposition of copayments under Plans B, C and D. Copayments are currently under further review based on comments received from the public. Savings are in the form of lower per member per month costs—copayments are not a funding source for the proposal.

Approximately $400 million of the $888 million in federal dollars is projected to be available from DSH payments. There is a pending regulation and plan to severely restrict states' ability to utilize these payments to enhance federal match; if those restrictions are implemented what are the implications for this 5-year waiver? Does the department plan to seek a waiver of the anticipated DSH policy? If the $400 million is not available to the state, what revisions does the department plan for the Medicaid program and for the waiver request. The waiver proposal converts current DSH payments to regular Medicaid payments and reduces the state's reliance on DSH. Some of the state general fund dollars that currently go to DSH payments will be used to draw down regular Medicaid and SCHIP federal match under the waiver proposal. The proposal reduces the state's reliance on DSH.

Mental health services

An unknown number of new clients with a Medicaid entitlement would be added to the CMHSPs' caseload under Plans C and D. We incorporate the questions raised by the Mental Health Association in Michigan on the funding assumptions included in this portion of the waiver. We are particularly concerned about the department's conclusion that a $56 million reduction in CMH non-Medicaid appropriations will not be harmful to those CMH clients who remain outside the scope of Medicaid. Also, how can the department know that the CMHs need only $56 million in '03 to serve the SMP population when the number of SMP clients statewide is not known to the state? What are the plans to reduce services and what are the limited services that will be available to these clients? The dollar figure included in the initial MIFamily proposal was established based on a preliminary analysis of data for current SMP beneficiaries. The Department continues to refine that analysis to ensure that payments to the CMHSPs are adequate to meet the needs of the new Medicaid group. Beneficiaries will be eligible for the full range of services provided through the CMHSPs—as long as the CMHSP authorizes the service.

What are the cost assumptions in the budget as CMHs are required to provide EPSDT services, mental health and behavioral health to children under 21. Is the state intending to reduce these benefits. The groups covered under the MIFamily proposal are not eligible for EPSDT services since children are not covered under the new groups. Children 18 and under are covered under Medicaid up to 150% of the federal poverty level (185% if under 1 year) and up to 200% FPL under MIChild. In addition, the Under 21 Medicaid category will still exist. None of the coverages under these programs are affected by the MIFamily proposal.

Does the department have any additional plans for changes in pharmaceutical coverage; will the copays apply to clients of the CMHs. The copays will apply to all drugs covered under the program. As noted, copays are under review based on public comments received by the Department.

While the proposal has some benefits, I am concerned that 1) citizens have not had enough time to review this proposal, 2) it's not clear that there will be adequate funding

or providers, and 3) it's not clear that there will be enough funding to sustain current benefits to current recipients.

Maximizing federal funds for health care in our state is a great goal, as are the goals of new eligibility for new groups of consumers, like pregnant women and working disabled adults, but this waiver could have major unintended consequences for people who need health insurance coverage and I urge you to delay applying for this waiver until advocates and consumers have the chance to study and comment and until these concerns have been addressed.

The information from MDCH regarding the 1115 HIFA waiver that expands Medicaid benefits raises a number of questions. While expanding coverage is the ideal, expansion at the expense of current coverage is not in the best interests of patients, providers, or the community at large.

Medicaid currently provides good, basic coverage for health services. However, there are already substantial limits on services. The new limits and co-pays seem very burdensome. Most families who receive Medicaid have trouble meeting basic needs. Where are they going to get the money for $10 and $20 co-pays. People just won't get preventative services and they won't get their prescriptions filled. So more folks will end up in the ER and in the hospital. There is no savings with this kind of approach.

As you know, there are major problems with Medicaid now. Many HMOs, hospitals, and other providers are financial problems due to inadequate reimbursement. Medicaid does not cover costs. How can the pool of recipients be increased without addressing this issue? Who will provide services to these patients? Services will be provided through enrolled Medicaid providers. Increasing the number of persons covered by Medicaid should have a positive effect on access in that many providers are seeing these patients now without receiving payment or with slow pay. Medicaid coverage will ensure that the providers are paid Medicaid rates, timely. The proposal may also have a positive effect on hospitals by increasing Medicaid and Medicare revenue.

While increased access could benefit the community, if there are no more providers and/or the providers bottom line encourages limiting services, there will be no benefit. If families who are already at risk for poor health outcomes face more barriers, they will not seek care early and are less likely to follow through with treatment if they can't afford it. There has to be a better way to expand coverage. The current proposals appear burdensome to both the patients and the providers, straining an already weak system.

On behalf of the board of directors and membership of the Michigan Association for Local Public Health I would like to express our concern at the rapid pace and limited opportunities for comment the waiver process has presented the public health community in Michigan thus far.

As an integral part of our states' safety net of health services and a key component of many of the locally based indigent care systems, local health departments would appreciate an expanded opportunity to comment on the waiver proposal and it's potential impact on Michigans most vulnerable citizens.

MDCH could have done much more to engage the stakeholders from our states' care,delivery,recipient and advocacy sectors to establish a more cooperative and collaborative environment in the development of this important step in expanding access to needed health care and services.

While we are disappointed in the manner in which this important process has been handled thus far,we hope that our continuing involvement and input will be welcomed as the process continues.

We at the Center are happy to see meeting the needs of the uninsured treated as a top policy priority and hope that providing access to care for all Michigan residents remains a top priority over the long term. Furthermore, we appreciate the plans attempts to involve local communities in the process and call for more support of community-based solutions to access to care problems.

The Association's Board of Directors has asked me to convey their comments and concerns regarding the proposed Section 1115 waiver application. The proposal, as described in the public meeting on February 4th and in the recent press release, will affect Michigan citizens with disabilities in a number of ways. Our member centers for independent living were pleased to hear the Governor recognize the importance of continuing access to Medicaid for individuals with disabilities as they pursue their employment objectives. We are also pleased that Mi Family recognizes the severe hardship faced by people on spend down. Both issues are critically important to many in the disability community, because access to Medicaid, especially such benefits as prescription drugs and personal assistance services, is absolutely essential to living a life of any reasonable quality.

We also applaud the capture of significant amounts of new federal funding, particularly at a time of state revenue shortfalls.

The Michigan Association of Centers for Independent Living is a member of the Coalition for Fairness in Health Policy, and the Board of Directors has endorsed the Coalition's stand regarding any Section 1115 waiver for the State of Michigan. Most notably, MACIL shares in the belief that any such proposal should be developed in consultation with representatives of those to be affected, that it should result in increased access to necessary health care services for Michigan residents, not just an increase in the number of persons who are labeled as insured, and that it should be based upon a cohesive health care policy for Michigan.

In short, while Michigan CILs recognize that public resources are limited, they oppose the concept of expanding coverage for some groups at the expense of others who need it, based upon arbitrary decisions about which population groups are most deserving of benefits.

Within the framework of the Coalition's position statement, then, we would offer the following comments on the Mi Family proposal, as we understand it:

General

- The proposal was not developed in consultation with representatives of the population groups to be affected. Both the Coalition for Fairness in Health Policy and the MI JOB Coalition, which is promoting establishment of an effective, consumer-responsive Medicaid Buy-In program in Michigan, have long and unsuccessfully sought a dialogue with the Department on the issues affected by this waiver. Now that the proposal has been announced, and the clock is running on the period of public comment, we have many grave concerns and questions, and only the sketchiest of written material on the proposal.

- The proposal appears to expand coverage for some populations, but this expansion may in many cases be less meaningful because of prohibitive co-pay requirements. Many groups will see a sharp reduction in benefits, and some, such as parents earning in excess of 100% of FPL, appear to lose all access to Medicaid.

- The rationale for the distribution of health care resources among different population groups has not been offered; the proposal clearly does not proceed from a coherent State health policy.

Budgetary Considerations

- The public has not been provided with anything in writing about how the waiver is to be funded over the next five years. Not everyone was able to attend the budget session at the Department's public meeting on February 4th, (because of the simultaneous meetings on benefits and eligibility), and those who did attend report a lack of clarity in the presentation. A clear written statement of how the waiver is to be financed over five years would be helpful.

- A particular concern to people with disabilities is what affect the expanded coverage will have on the limited resources of the community mental health system.

Expansion of coverage to individuals in 1619(b)

- We appreciate the attempt to expand health coverage for people with disabilities who want to work and fear the loss of Medicaid. However, the population group covered by this initiative--those SSI recipients currently eligible for Medicaid under Section 1619 (b)--is extremely small--about 4,000 people, according to the Social Security Administration. Many more people in Michigan need this kind of help, including SSDI recipients on spend down, people with disabilities who are on neither SSI nor SSDI, and people on SSI who have been unable to access Section 1619 (b).

- The proposal that Section 1619(b) would become the gateway to health coverage for working people with disabilities is extremely problematic because the program is so hard to access. Our consumers report that SSA field staff provide erroneous, confusing and conflicting information on eligibility, and it appears that some staff lack the incentive to extend the extra help required to make the program work for consumers.

SSA senior management at the national and regional level acknowledge the problem, and have tried to address it in various ways under the Ticket to Work/Work Incentives Improvement Act. Lack of sufficient progress to date, however, has left SSI recipients suspicious of the program and unwilling to risk their health coverage by pursuing decent jobs. The Department has not provided any indication that it will try to address this issue.

- While the Department has indicated that 1619(b) recipients would be able to increase incomes to 350% of FPL and to save for retirement, the basic $2,000 limitation on accumulation of other assets continues to lock them in poverty. It means that people will be unable to save for emergencies such as vehicle repair or health care costs not covered by Medicaid, nor to make home modifications or down payments, save for college expenses, or do anything else to improve their financial security. A meaningful Medicaid Buy-In program would allow people's incomes and assets to grow, and simply capture an increasing portion of the cost of coverage through premiums.

- People with disabilities who accumulate 40 quarters of work experience become at risk of losing their Medicaid. That amount of work history qualifies them for SSDI, which becomes their source of support if they stop working for reasons related to their disability. They are then eligible for Medicare, but not Medicaid, and no longer have access to key Medicaid benefits. It is this sort of regulatory morass which has made SSI recipients so wary of doing anything that jeopardizes their health coverage. Confining the expansion to the small 1619(b) population further fragments the work incentive system. Only greatly expanding Medicaid coverage to the general disability population can break down the barrier of fear and suspicion that keeps people dependent on public assistance.

Other Benefits/Eligibility Issues

- There is growing evidence of a link between poverty, inadequate health care, and the incidence of disability and chronic conditions. The populations affected by the proposed waiver include many people with disabilities (excluding those on SSI or people with developmental disabilities). Contrary to the Department's press release, then, many people with disabilities will in fact be affected by the waiver. The imposition of co-pay requirements on parents below 100% of FPL, and childless adults below 35% of FPL in Plans B, C, and D, will make health care too expensive for many beneficiaries, including people with disabilities.

- Numerous important benefits will no longer be covered at all for these groups, such as podiatrist services, physical and occupational therapy, diagnostic, rehabilitative, and respiratory care services, and personal care. The importance of preventive care does not seem to be addressed in these plans.

- Early Periodic Screening Diagnosis and Treatment services are reduced for people under 21. Prevention of secondary disabling conditions is extremely cost effective.

- While the elimination of spend down requirements for these groups is laudable, the proposal seems to indicate that parents and caretaker relatives earning more than 100% of poverty will no longer be able to access Medicaid at all through spend down.

The Michigan Council for Maternal and Child Health (MCMCH) advocates for increased access to health insurance for pregnant women and children. Continuity and consistency of care for children is critical to their health and well-being. Access to prenatal care is critical to achieve healthy birth outcomes and reduce the incidence of infant mortality and morbidity.

Having said that, while it appears that benefits will remain the same for children, the first priority of the SCHIP program was to increase insurance coverage for children. MCMCH is concerned that the state of Michigan maintain the infrastructure and capacity of the MI Child program to reach uninsured children with critical primary and preventive care as the economy fluctuates during the life of this waiver. We would also appreciate clarification regarding the proposal to move children on MICHILD from the fee for service BCBSM program to managed care.

Secondly, caretakers and parent relatives who care for young children and particularly children with special needs will have copays and limited coverage. These parents and caretakers are living below the poverty level and required co-payments and possible premiums in the future will further jeopardize their ability to access basic health and mental health services.

Finally, we are concerned that the whole health system is being asked to do more with fewer resources. Even prior to the waiver, our board members have been concerned about reimbursement rates for Medicaid resulting in an increasing number of providers who will NOT take Medicaid, and as well as reductions in funding for prevention services and health education. We are concerned that services such as transportation, outreach, and optional health services currently available to the Medicaid covered population will no longer be available.

We are also concerned that the pressures of expanded coverage and less flexibility in the use of state and local funds will result in county mental health entities dropping optional services such as wraparound and infant mental health services that are significant for young children and youth.

While this plan may be cost-neutral, it does not appear to be benefit-neutral, and this is of concern to MCMCH.